



PROFESSIONAL STAFF ASSOCIATION HEALTH CLEARANCE INSTRUCTIONS

Welcome to Los Angeles County, Department of Health Services. You are required to be cleared by Employee Health Services (EHS) prior to beginning your assignment. You must successfully complete the Human Resources in-processing and criminal background check prior to beginning the EHS health clearance process. In this packet includes health screening forms and questionnaires that should be completed prior to your visit to EHS. The completed forms should be presented to EHS on the day of your appointment/visit. Please bring the following forms with you to EHS at your appointment/visit. **There are two options to meet this requirement:**

OPTION 1: Health screening provided by your physician or licensed health care professional

Return completed **Form E2** to EHS:

- ☒ Section I - Completed by a licensed health care professional
- ☒ Section II - Completed by you
- ☒ Section III - Completed by your employer, school, or self (personal contract)

OPTION 2: Health screening provided by EHS

Please bring the following forms with you to EHS:

- ☒ **B-NC** Page 1 completed by you
- ☒ **K-NC** Complete as applicable
- ☒ **T1-NC** Must be signed in the presence of EHS
- ☒ **T4-NC** Must be signed in the presence of EHS

Only if respiratory protection is needed for your assignment, you must complete one of the following medical questionnaire below:

- ☐ **O-NC** For respirator greater than N-95 mask OR
- ☐ **P-NC** For N-95 respirator

By providing these documents, you can help expedite the processing for an EHS health clearance:

1. Tuberculosis (TB) Test Record (a copy of any one of the following):

Completed within the last 12 months

- ☐ 2 negative Tuberculin Skin Test (TST) records documented in millimeters (This is a two-step TST)
- ☐ 1 negative TST record documented in millimeters
- ☐ 1 negative single blood assay for M. tuberculosis (BAMT)

For a positive TB result, submit a Chest X-Ray Report within the last 12 months

- ☐ 1 positive TST record documented in millimeters with a Chest X-Ray Report
- ☐ 1 positive BAMT record with a Chest X-Ray Report

2. Immunizations Record and/or Titers to the following:

- | | | |
|----------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Varicella | <input type="checkbox"/> Acellular Pertussis |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Tetanus | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Hepatitis B |

The following will be obtained at EHS:

- A two-step TST will be conducted if you cannot provide documentation of 2 negative TST records within the previous 12 months. This may require a total of 3 office visits.
- A TST will be conducted if you can only provide documentation of 1 negative TST record within the previous 12 months. This may require a total of 2 office visits.
- If you have been documented with a positive TST or positive BAMT result, you will be required to have a baseline chest x-ray prior to work assignment **OR** provide written documentation of a normal chest x-ray taken no more than 12 months prior to work assignment.
- EHS will assess the immunization documents you provide to determine if you meet evidence of immunity to vaccine-preventable diseases as a requirement for your work assignment.

APPOINTMENT

- ☐ **YOUR APPOINTMENT IS SCHEDULED ON _____ AT _____ AM / PM.**
- ☐ **APPOINTMENT NEEDED, PLEASE CALL _____.**
- ☐ **NO APPOINTMENT NEEDED, PLEASE WALK IN DURING THE FOLLOWING OFFICE HOURS:**

DAY	TIME	LOCATION
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

If you have any questions or need assistance, please contact the facility EHS office.

Thank you,

DHS EMPLOYEE HEALTH SERVICE



CONFIDENTIAL

**NON-DHS/NON-COUNTY WORKFORCE MEMBER
TUBERCULOSIS HISTORY AND EVIDENCE OF IMMUNITY**

See General Instructions on Last Page

LAST NAME:		FIRST, MIDDLE NAME:		BIRTHDATE:		IDENTIFICATION NO.:	
HOME ADDRESS:				CITY:		STATE: ZIP CODE:	
E-MAIL ADDRESS:				HOME PHONE NO.:		CELL PHONE NO.:	
JOB CLASSIFICATION:		DHS FACILITY:		DEPT/DIVISION:		WORK AREA/UNIT: SHIFT:	
NAME OF SCHOOL/EMPLOYER (If applicable):				PHONE NO.:		CONTACT PERSON:	

FOR COMPLETION BY WORKFORCE MEMBER (WFM)

TUBERCULOSIS QUESTIONNAIRE

NOT YES SURE NO	
	TUBERCULOSIS (TB) HISTORY
<input type="checkbox"/>	1. Do you have history of a negative TB skin test?
<input type="checkbox"/>	2. Do you have documentation of your negative test from the last 12 months?
<input type="checkbox"/>	3. Do you have a history of a positive TB skin test?
<input type="checkbox"/>	4. Do you have documentation of your positive skin test in millimeters?
<input type="checkbox"/>	5. Do you have documentation of a chest X-ray within the last year?
<input type="checkbox"/>	6. Have you received treatment for TB (INH)?
<input type="checkbox"/>	If "yes", how many months? _____
<input type="checkbox"/>	7. Do you have treatment documentation?
<input type="checkbox"/>	8. Have you ever been diagnosed as having active or infectious TB?
<input type="checkbox"/>	9. Have you received a TB vaccine called BCG?
<input type="checkbox"/>	10. Have you had a weakened immune system due to (check all that applies):
	<input type="checkbox"/> Chemotherapy <input type="checkbox"/> HIV <input type="checkbox"/> Organ transplant <input type="checkbox"/> Leukemia <input type="checkbox"/> Cancer or medications <input type="checkbox"/> Hodgkin's Disease <input type="checkbox"/> Steroids (e.g., prednisone)
	Note: Having immunodeficiency increases a person's risk for active TB infection/disease. If you think you may be immunocompromised you should consult with your physician or licensed health care professional. DHS-EHS does not test for HIV or related diseases.
	TUBERCULOSIS (TB) SCREENING
<input type="checkbox"/>	11. Do you have a cough lasting longer than three (3) weeks?
<input type="checkbox"/>	12. Do you cough up blood?
<input type="checkbox"/>	13. Do you have unexplained or unintended weight loss?
<input type="checkbox"/>	14. Do you have night sweats (not related to menopause)?
<input type="checkbox"/>	15. Do you have a fever or chills?
<input type="checkbox"/>	16. Do you have excessive sputum?
<input type="checkbox"/>	17. Do you have excessive fatigue?
<input type="checkbox"/>	18. Have you had recent close contact with a person with TB?
NON-DHS/NON-COUNTY WORKFORCE MEMBER SIGNATURE	
DATE	

LAST NAME	FIRST NAME	BIRTHDATE	IDENTIFICATION NO.
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FOR COMPLETION BY EMPLOYEE HEALTH STAFF – OR – DESIGNATED WFM AGENCY

TUBERCULOSIS DOCUMENTATION HISTORY

A	TUBERCULIN SKIN TEST RECORD										STATUS <small>Indicate: Reactor Non-Reactor Converter</small>
	0.1 ml of 5 tuberculin units (TU) purified protein derivative (PPD) antigen intradermal										
	DATED PLACED	STEP	MANUFACTURER	LOT #	EXP	SITE	*ADM BY (INITIALS)	DATE READ	*READ BY (INITIALS)	RESULT	
		1st									
	2nd										
If either result is positive, send for CXR and complete Section C below.											

OR

B	Negative BAMT (<12 months)	Date:	Results	<input type="checkbox"/> LA County <input type="checkbox"/> Outside Document	STATUS
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**If CXR is positive for TB, DO NOT CLEAR for hire/assignment.
 Refer Workforce Member for immediate medical care.**

C	Positive TST	Date:	Results _____mm	<input type="checkbox"/> LA County <input type="checkbox"/> Outside Document	STATUS
	CXR (<12 months)	Date:	Results _____	<input type="checkbox"/> LA County <input type="checkbox"/> Outside Document	

OR

D	Positive BAMT	Date:	Results _____	<input type="checkbox"/> LA County <input type="checkbox"/> Outside Document	STATUS
	CXR (<12 months)	Date:	Results _____	<input type="checkbox"/> LA County <input type="checkbox"/> Outside Document	

OR

E	History of Active TB with Treatment	Date:	_____months with _____	<input type="checkbox"/> Outside Document	STATUS
	CXR (<12 months)	Date:	Results _____	<input type="checkbox"/> Outside Document	

OR

F	History of LTBI Treatment	Date:	_____months with _____	<input type="checkbox"/> Outside Document	STATUS
	CXR (<12 months)	Date:	Results _____	<input type="checkbox"/> Outside Document	

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	IDENTIFICATION NO.
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IMMUNIZATION DOCUMENTATION HISTORY (THESE VACCINATIONS ARE MANDATORY)							
	Date Received	Titer	If not immune, give Vaccination x 2, unless Rubella x 1		Date Received	Vaccine	Declined Vaccination
G	Measles	<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune <input type="checkbox"/> Equivocal <input type="checkbox"/> Laboratory confirm of disease	OR	X 2			OR <input type="checkbox"/> If WFM declines, WFM must complete Form K-NC AND specify reason(s) for declination.
	Mumps	<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune <input type="checkbox"/> Equivocal <input type="checkbox"/> Laboratory confirm of disease	OR	X 2			OR <input type="checkbox"/> If WFM declines, WFM must complete Form K-NC AND specify reason(s) for declination.
	Rubella	<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune <input type="checkbox"/> Equivocal <input type="checkbox"/> Laboratory confirm of disease	OR	X 1			OR <input type="checkbox"/> If WFM declines, WFM must complete Form K-NC AND specify reason(s) for declination.
	Varicella	<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune <input type="checkbox"/> Equivocal <input type="checkbox"/> Laboratory confirm of disease	OR	X 2			OR <input type="checkbox"/> If WFM declines, WFM must complete Form K-NC AND specify reason(s) for declination.

AND

	Vaccination	Date Received		Declined Vaccine
H	Tetanus-diphtheria (Td) Every 10 years		<input type="checkbox"/> Verbal <input type="checkbox"/> Document	<input type="checkbox"/>
	Aracellular Pertussis (Tdap) X 1		<input type="checkbox"/> Verbal <input type="checkbox"/> Document	<input type="checkbox"/>

AND

	Vaccination (MANDATORY for WFM who have potential to be exposed to blood or body fluid)	Date Received	Immunity	Declined Vaccine
I	Hepatitis B (HBsAb)		<input type="checkbox"/> Reactive <input type="checkbox"/> Non reactive <input type="checkbox"/> N/A	<input type="checkbox"/>

AND

	Vaccination (VOLUNTARY)	Date Received	Location Received		Declined Vaccine
J	Seasonal Influenza (Annually)			<input type="checkbox"/> Verbal <input type="checkbox"/> Document	<input type="checkbox"/>



**ATTACH SUPPORTING DOCUMENTATION(S) WITH THIS FORM
 INCLUDING FORM K-NC IF WFM DECLINED VACCINATION(S)**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 C.F.R. Part 1635

GENERAL INSTRUCTION ON NEXT PAGE

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	IDENTIFICATION NO.
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 **GENERAL INSTRUCTIONS FOR EACH SECTION**

SECTION	
TUBERCULOSIS DOCUMENTATION HISTORY	
ALL WORKFORCE MEMBER (WFM) SHALL BE SCREENED FOR TB UPON HIRE/ASSIGNMENT	
A	<p>WFM shall receive a baseline TB screening using two-step Tuberculin Skin Test (TST). Step 1: Administer TST test, with reading in seven days. Step 2: After Step 1 reading is negative, administer TST test, with reading within 48-72 hours. If both readings are negative, WFM is cleared to work. WFM shall receive either TST or BAMT and symptom screening annually.</p> <p style="margin-left: 20px;">a. Documentation of negative TST within 12 months prior to placement will be accepted. WFM shall receive a one-step TST with reading within 48-72 hours. If result is negative, WFM is cleared to work;</p> <p style="margin-left: 20px;">b. Documentation of negative two-step TST within 12 months prior to placement will be accepted. WFM is cleared to work.</p> <p>If TST is positive, record results and continue to Section C.</p>
B	<p>WFM shall receive a baseline TB screening using a single blood assay for M. tuberculosis (BAMT). If negative result, WFM is cleared to work. WFM shall receive either TST or BAMT and symptom screening annually.</p> <p style="margin-left: 20px;">a. Documentation of negative BAMT within 12 months will be accepted. WFM is cleared to work.</p> <p>If BAMT is positive, record results and continue to Section D.</p>
TST POSITIVE RESULTS	
If CHEST X-RAY IS POSITIVE, DO NOT CLEAR FOR HIRE/ASSIGNMENT, AND REFER WORKFORCE MEMBER FOR IMMEDIATE MEDICAL CARE	
C	<p>If TST is positive during testing in Section A or C above, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. WFM shall be symptom screened for TB annually.</p>
D	<p>If BAMT is positive during testing in Section D above, send for a CXR. If CXR is negative, WFM is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. WFM shall be symptom screened for TB annually.</p>
E	<p>If WFM have a documented history of active TB, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. If documentation is supported, WFM is cleared to work. WFM shall be symptom screened for TB annually. Record documentation result in this section.</p>
F	<p>If WFM have a documented history of latent tuberculosis infection (LTBI) treatment, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. If documentation is supported, WFM is cleared to work. WFM shall be symptom screened for TB annually. Record documentation result in this section.</p>
IMMUNIZATION DOCUMENTATION HISTORY	
<p>Documentation of immunization or adequate titers will be accepted. If WFM is not immune against communicable diseases as listed in this section, WFM shall be immunized (unless medically contraindicated). WFM who declines the vaccination(s) must sign the mandatory declination form. WFM who declines the vaccination(s) may be restricted from patient care areas of the hospital or facility. If WFM is non-immune or decides at a later date to accept the vaccination, DHS or WFM contract agency will make the vaccination available.</p>	
G	<p>Documentation of laboratory evidence of immunity or laboratory confirmation of disease will be accepted OR documentation of two doses (live measles, mumps and varicella) and one dose of live rubella virus vaccine. Measles vaccine shall be administered no earlier than one month (minimum 28 days) after the first dose. Mumps second dose vaccine vary depending on state or local requirements. Varicella doses shall be at least 4 week between doses for WFM. If Equivocal, WFM needs either vaccination or re-draw with positive titer. DHS-EHS must be notified if WFM does not demonstrate evidence of immunity.</p>
H	<p>Td – After primary vaccination, Td booster is recommended every 10 years. If unvaccinated WFM, primary vaccination consists of 3 doses of Td; 4-6 weeks should separate the first and second doses; the third dose should be administered 6-12 months after the second dose.</p> <p>Tdap should replace a one time dose of Td for HCP aged 19 through 64 years who have not received a dose of Tdap previously. An interval as short as 2 years or less from the last dose of Td is recommended for the Tdap dose.</p>
I	<p>All WFM who have occupational exposure to blood or other potentially infectious materials shall have a documented post vaccination antibody to Hepatitis B surface antigen HBsAb (anti-HBs). Hepatitis B vaccine series is available to WFM. Non-responders should be considered susceptible to HBV and should be counseled regarding precautions to prevent HBV infection and the need to obtain HBIG prophylaxis for any known or probable parenteral exposure to HBsAg positive blood.</p>
J	<p>Seasonal influenza is offered annually to WFM when the vaccine becomes available.</p>

This form and its attachment(s), if any, such as medical records shall be maintained and filed at non-DHS/non-County workforce member's School/Employer. The School/Employer shall verify completeness of DHS-Employee Health Services (EHS) form(s) and ensure confidentiality of non-DHS/non-County WFM health information.

Upon request by DHS-EHS, the non-DHS/non-County WFM School/Employer shall have this form and its attachment(s) readily available within four (4) hours.

All workforce member health records are confidential in accordance with federal, state and regulatory requirements.



CONFIDENTIAL

**NON-DHS/NON-COUNTY WORKFORCE MEMBER
DECLINATION FORM**

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:	
JOB CLASSIFICATION:	DHS FACILITY:	DEPT/DIVISION:	WORK AREA/UNIT:	SHIFT:
NAME OF SCHOOL/EMPLOYER (If applicable):		PHONE NO.:	CONTACT PERSON:	

Please check in the section(s) as apply AND indicate reason for the declination. Submit original to DHS-EHS.

I. ☐ 8 CCR §5199. Appendix C1 - Vaccination Declination Statement (Mandatory)*

Please check as apply: ☐ Measles ☐ Mumps ☐ Rubella ☐ Varicella ☐ Td/Tdap

I understand that due to my occupational exposure to aerosol transmissible diseases, I may be at risk of acquiring infection as indicated above. I have been given the opportunity to be vaccinated against this disease or pathogen at no charge to me. However, I decline this vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring the above infection, a serious disease. If in the future I continue to have occupational exposure to aerosol transmissible diseases and want to be vaccinated, I can receive the vaccination from my School/Employer or DHS-Employee Health Services (EHS) at no charge to me.

Reason for declination: _____

☐ Seasonal Influenza

Reason for declination (check as apply):

- ☐ I am allergic to vaccine components.
☐ I believe I can get the flu if I get the shot.
☐ I am concerned about vaccine side effects.
☐ It's against my personal belief.

- ☐ I don't believe I need it.
☐ I'm concerned about vaccine safety.
☐ I do not like needles.
☐ Other: _____

II. ☐ 8 CCR §5193. Appendix A-Hepatitis B Vaccine Declination (Mandatory)*

☐ Hepatitis B

I understand that due to my occupational exposure to blood or other potentially infectious material (OPIM) I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to me. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or OPIM and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series from my School/Employer or DHS-EHS at no charge to me.

Reason for declination: _____

III. ☐ Specialty Surveillance Declination (Mandatory)**

Please check as apply: ☐ Asbestos ☐ Hazardous/Anti-Neoplastic Drugs ☐ Other: _____

I understand that due to my occupational exposure as indicated above, I am eligible and have been given the opportunity to enroll in the Medical Surveillance Program. This will enable me to receive specific initial, periodic

PLEASE SIGN ON PAGE 2

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:
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and exit medical examinations for the hazard identified above, at no charge to me and at a reasonable time and place.

However, I decline to be enrolled in this program at this time. I understand that by declining this enrollment, I will not be medically monitored for occupational exposure to this hazard. I understand that it is strongly recommended that I complete a medical questionnaire or examination. I also understand that if in the future I continue to have occupational exposure to the hazard identified above and I want to be enrolled in the Medical Surveillance Program, I can do so at any time at no charge to me.

Reason for declination: _____

SIGN BELOW

By signing this, I am declining as indicated on this form.

WORKFORCE MEMBER SIGNATURE		DATE
SCHOOL/EMPLOYER (PRINT NAME)	SIGNATURE	DATE

**MAKE A COPY FOR YOUR RECORDS
SUBMIT ORIGINAL AND ANY SUPPORTING DOCUMENT(S)**

*Vaccination(s) is available to all workforce members (WFM), and free of charge for County employees and volunteers. Non-County WFM should obtain the vaccinations from their physician or licensed health care professional. Services provided through DHS will be billed to the non-County WFM School/Employer, as appropriate.

**Non-County WFM who has potential exposure to occupational hazards will be included in the surveillance program, but will not have their assessments done through the County, unless specified in contract/agreement. Medical surveillance/post-exposure regulations are the responsibility of the school/contract agency. If the non-County WFM School/Employer chooses to have DHS-Employee Health Services (EHS) to perform such surveillance/post-exposure services, the non-County WFM School/Employer will be billed accordingly. Emergency services will be provided post-exposure within the allowable time frames, but will be billed to the contractor/agency, as appropriate.

Workforce member must complete this form if declining DHS recommended and mandatory vaccinations or medical surveillance program. The School/Employer must verify completeness and ensure declination form is submitted to DHS-EHS. **The School/Employer must notify DHS-EHS if workforce member does not provide evidence of immunity.**

This form and its attachment(s), if any, such as health records shall be maintained and kept in workforce member EHS health file.



NON-DHS/NON-COUNTY WORKFORCE MEMBER GENERAL CONSENT

LAST NAME:		FIRST, MIDDLE NAME:		BIRTHDATE:		IDENTIFICATION NO.:			
JOB CLASSIFICATION:			DHS FACILITY:		DEPT/DIVISION:		WORK AREA/UNIT: SHIFT:		
E-MAIL ADDRESS:				WORK PHONE:		CELL/PAGER NO.:		SUPERVISOR NAME:	
NAME OF SCHOOL/EMPLOYER <i>(If applicable):</i>						PHONE NO.:		CONTACT PERSON:	

Medical Consent: The undersigned Los Angeles County Department of Health Services workforce member, applicant, and/or responsible relative or person hereby consent to, authorize and request the Department of Health Services (DHS), its physicians, nursing and medical personnel assigned to and authorized by Employee Health Services to administer and perform any and all medical examinations and treatments required for County services. This may include, but not limited to, diagnostic procedures, medical surveillance, post exposure evaluation, tuberculosis screening, drawing blood to determine immunity to infectious diseases, vaccinations and immunizations against disease which may now or during the course of employment/assignment, be deemed advisable or necessary in accordance with federal, state, and local guidelines.

The undersigned further consent to, and authorize, demonstration and/or observations of patient during administration of medical treatment, by physicians, medical students, student nurses and any other proper student or technician whose presence is deemed appropriate by the attending physician.

The undersigned also agrees to fully comply with the rules of DHS and specifically affirm that the Director of DHS will be sole judge of such observance. They further agree that if the workforce member fails to comply with such rules, he/she may be forthwith discharge.

Release of the Information: Upon inquiry, DHS may make available to the public certain basic information about the workforce member, including name, address, age, sex, general description of the reason for treatment, general nature of the injury, and general condition.

The undersigned acknowledges that all workforce members records maintained at any Los Angeles County Department of Health Services facility may be made available for workforce member care, statistical analysis, or research and/or special projects to authorized uses or release as required by law.

CONTINUE ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:
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The undersigned certifies that he/she has read the foregoing, receiving a copy thereof and is the patient, or duly authorized by or on behalf of the workforce member to execute the above and accept its terms.

NON-DHS/NON-COUNTY WORKFORCE MEMBER OR RESPONSIBLE PERSON SIGNATURE		DATE	TIME
WITNESS SIGNATURE		DATE	TIME
WITNESS (PRINT NAME)		RELATIONSHIP TO WORKFORCE MEMBER	
EHS STAFF (PRINT)	EHS SIGNATURE	DATE	TIME

This form and its attachment(s), if any, such as health records shall be filed in workforce member's EHS medical file. All health records of workforce member are confidential in accordance with federal, state and regulatory requirements.

DHS-EHS will obtain the workforce member's written authorization before using or disclosing health information, include to self, unless the disclosure is required by State or Federal law such as to a public health authority or governmental regulatory agency.

DHS is permitted to disclose protected health information, without authorization, to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury, or disability. This would include, for example, the reporting of a disease or injury; reporting vital events; and conducting public health surveillance, investigations, or interventions.

Workforce members have the right to access their medical records and obtain a copy, thereof, within fifteen (15) days after the request.



Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES NON-COUNTY/NON-DHS WORKFORCE MEMBER NOTICE OF PRIVACY PRACTICES

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:	
JOB CLASSIFICATION:	DHS FACILITY:	DEPT/DIVISION:	UNIT/AREA:	SHIFT:
E-MAIL ADDRESS:	WORK PHONE NO.:	CELL/PAGER NO.:	SUPERVISOR NAME:	
NAME OF SCHOOL/EMPLOYER (If applicable):		PHONE NO.:	CONTACT PERSON:	

Effective Date: _____

ACKNOWLEDGMENT OF RECEIPT

By signing this form, you acknowledge receipt of the Notice of Privacy Practices for Los Angeles County Department of Health Services (DHS). DHS Notice of Privacy Practices (the Notice) describes how your protected health information may be used and disclosed and how you can get access to this information. Please read the Notice carefully. The Notice of Privacy Practices is subject to change. Any change in the Notice will be posted on DHS website at www.dhs.lacounty.gov, or you may request a copy from our staff.

I acknowledge receipt of the Notice of Privacy Practices for Los Angeles County DHS.

NON-DHS/NON-COUNTY WORKFORCE MEMBER SIGNATURE:	DATE:
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INABILITY TO OBTAIN ACKNOWLEDGMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe the good faith effort made to obtain the individual's acknowledgment, and the reason why the acknowledgement was not obtained:

Reasons why the acknowledgement was not obtained:

- ☐ Non-DHS/Non-County Workforce Member refused to sign
☐ Other reason or comments:

EHS STAFF NAME (PRINT):	SIGNATURE:	DATE:
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EMPLOYEE HEALTH SERVICES

CONFIDENTIAL NON-DHS/NON-COUNTY WORKFORCE MEMBER 8 CCR SECTION 5144 – APPENDIX C RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

GENERAL INFORMATION on last page

Questionnaire for respirators greater than N-95

WORKFORCE MEMBER TO COMPLETE ONCE EVERY FOUR (4) YEARS OR AS NEEDED

To the EMPLOYER:

Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the WORKFORCE MEMBER:

Can you read and understand this questionnaire (check one): ☐ Yes ☐ No

Your employer must allow you to answer the questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

SECTION 1 – PART A (MANDATORY)

The following information must be provided by every workforce member who has been selected to use any type of respirator (please print).

				TODAY'S DATE:	
LAST NAME		FIRST, MIDDLE NAME		BIRTHDATE	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
HEIGHT FT IN	WEIGHT LBS	JOB CLASSIFICATION		IDENTIFICATION NO.	
PHONE NUMBER		Best Time to reach you?	Has your employer told you how to contact the health care professional who will review this questionnaire? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Check type of respirator you will use (you can check more than one category): <input type="checkbox"/> N, R, Or P disposal respirator (filter-mask, non-cartridge type only) <input type="checkbox"/> Other type (specify): _____	
Have you worn a respirator? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "yes", what type:

SECTION 2 – PART A (MANDATORY)

Questions 1 through 9 below must be answered by every workforce member who has been selected to use any type of respirator (please check "YES," "NOT SURE," or "NO").

NOT YES SURE NO	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2. Have you ever had any of the following conditions:
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	a. Seizures (fits)
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	b. Diabetes (sugar disease)
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	c. Allergic reactions that interfere with your breathing
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	d. Claustrophobia (fear of closed-in places)
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	e. Trouble smelling odors

CONTINUE ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:
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NOT YES SURE NO	
	3. Have you ever had any of the following pulmonary or lung problems:
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	a. Asbestosis
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	b. Asthma
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	c. Chronic bronchitis
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	d. Emphysema
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	e. Pneumonia
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	f. Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	g. Silicosis
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	h. Pneumothorax (collapsed lung)
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	i. Lung cancer
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	j. Broken ribs
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	k. Any chest injuries or surgeries
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	l. Any other lung problem that you've been told about?
	If "YES," please explain:
	4. Do you currently have any of the following symptoms of pulmonary or lung illness:
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	a. Shortness of breath
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	c. Shortness of breath when walking with other people at an ordinary pace on level ground
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	d. Have to stop for breath when walking at your own pace on level ground
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	e. Shortness of breath when washing or dressing yourself
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	f. Shortness of breath that interferes with your job
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	g. Coughing that produces phlegm (thick sputum)
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	h. Coughing that wakes you early in the morning
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	i. Coughing that occurs mostly when you are lying down
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	j. Coughing up blood in the last month
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	m. Chest pain when you breathe deeply
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	n. Any other symptoms that you think may be related to lung problems?
	If "YES," please list symptoms:
	5. Have you ever had any of the following cardiovascular or heart problems:
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	a. Heart attack
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	b. Stroke
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	c. Angina
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	d. Heart failure
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	e. Swelling in your legs or feet (not caused by walking)
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	f. Heart arrhythmia (heart beating irregularly)
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	g. High blood pressure
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	h. Any other heart problem that you've been told about?
	If "YES," please explain:

CONTINUE ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:
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NOT YES SURE NO	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	6. Have you ever had any of the following cardiovascular or heart symptoms:
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	a. Frequent pain or tightness in your chest
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	b. Pain or tightness in your chest during physical activity
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	c. Pain or tightness in your chest that interferes with your job
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	d. In the past two years, have you noticed your heart skipping or missing a beat?
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	e. Heartburn or indigestion that is not related to eating
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	f. Any other symptoms that you think may be related to heart or circulation problems?
	If "YES," please list symptoms:
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	7. Do you currently take medication for any of the following problems?
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	a. Breathing or lung problems
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	b. Heart trouble
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	c. Blood pressure
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	d. Seizures (fits)
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	8. If you've ever used a respirator, have you ever had any of the following problems?
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	a. Eye irritation
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	b. Skin allergies or rashes
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	c. Anxiety
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	d. General weakness or fatigue
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	e. Any other problem that interferes with your use of a respirator?
	If "YES," please explain:
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?

SECTION 2 – PART B ☐ **NOT APPLICABLE**

Questions 10 through 15 below must be answered by every workforce member who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). For workforce members who have been selected to use other types of respirators, answering these questions is **VOLUNTARY**.

NOT YES SURE NO	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	10. Have you ever lost vision in either eye (temporarily or permanently)?
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	11. Do you currently have any of the following vision problems:
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	a. Wear contact lenses
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	b. Wear glasses
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	c. Color blind
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	d. Any other eye or vision problem?
	If "YES," please explain:
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	12. Have you ever had an injury to your ears, including a broken ear drum?
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	13. Do you currently have any of the following hearing problem:

CONTINUE ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:
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NOT YES SURE NO		
<input type="checkbox"/>	<input type="checkbox"/>	a. Difficulty hearing
<input type="checkbox"/>	<input type="checkbox"/>	b. Wear a hearing aid
<input type="checkbox"/>	<input type="checkbox"/>	c. Any other hearing or ear problem
		If "YES," please explain:
<input type="checkbox"/>	<input type="checkbox"/>	14. Have you ever had a back injury?
		15. Do you currently have any of the following musculoskeletal problems:
<input type="checkbox"/>	<input type="checkbox"/>	a. Weakness in any of your arms, hands, legs, or feet
<input type="checkbox"/>	<input type="checkbox"/>	b. Back pain
<input type="checkbox"/>	<input type="checkbox"/>	c. Difficulty fully moving your arms and legs
<input type="checkbox"/>	<input type="checkbox"/>	d. Pain and stiffness when you lean forward or backward at the waist
<input type="checkbox"/>	<input type="checkbox"/>	e. Difficulty fully moving your head up or down
<input type="checkbox"/>	<input type="checkbox"/>	f. Difficulty fully moving your head side to side
<input type="checkbox"/>	<input type="checkbox"/>	g. Difficulty bending at your knees
<input type="checkbox"/>	<input type="checkbox"/>	h. Difficulty squatting to the ground
<input type="checkbox"/>	<input type="checkbox"/>	i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.
<input type="checkbox"/>	<input type="checkbox"/>	j. Any other muscle or skeletal problem that interferes with using a respirator?
		If "YES," please explain:

SECTION 2 – PART C
☐ **NOT APPLICABLE**

Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

NOT YES SURE NO		
<input type="checkbox"/>	<input type="checkbox"/>	1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen?
<input type="checkbox"/>	<input type="checkbox"/>	If "YES," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions?
<input type="checkbox"/>	<input type="checkbox"/>	2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals.
		If "YES," name the chemicals if you know them:
		a. _____ d. _____
		b. _____ e. _____
		c. _____ f. _____
		3. Have you ever worked with any of the materials, or under any of the conditions, listed below:
<input type="checkbox"/>	<input type="checkbox"/>	a. Asbestos
<input type="checkbox"/>	<input type="checkbox"/>	b. Silica (e.g., in sandblasting)
<input type="checkbox"/>	<input type="checkbox"/>	c. Tungsten/cobalt (e.g., grinding or welding this material)
<input type="checkbox"/>	<input type="checkbox"/>	d. Beryllium
<input type="checkbox"/>	<input type="checkbox"/>	e. Aluminum

CONTINUE ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:
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NOT YES SURE NO	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	f. Coal (for example, mining)
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	g. Iron
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	h. Tin
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	i. Dusty environment
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	j. Any other hazardous exposures?
	If "YES," describe these exposure:
	4. List any second jobs or side businesses you have:
	a. _____ d. _____
	b. _____ e. _____
	c. _____ f. _____
	5. List your previous occupations:
	a. _____ d. _____
	b. _____ e. _____
	c. _____ f. _____
	6. List your current and previous hobbies:
	a. _____ d. _____
	b. _____ e. _____
	c. _____ f. _____
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	7. Have you been in the military services?
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If "YES," were you exposed to biological or chemical agents (either in training or combat)?
	Please list chemicals (if known):
	a. _____ d. _____
	b. _____ e. _____
	c. _____ f. _____
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	8. Have you ever worked on a HAZMAT team?
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	9. Other than medications for breathing and lung problems, heart troubles, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications)?
	If "YES," name the medications if you know them:
	a. _____ e. _____
	b. _____ f. _____
	c. _____ g. _____
	d. _____ h. _____
	10. Will you be using any of the following items with your respirator(s)?
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	a. HEPA Filters
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	b. Canisters (for example, gas masks)
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	c. Cartridges
	11. How often are you expected to use the respirator(s)? Check "YES", "NOT SURE," or "NO" to all answers that apply to you.

CONTINUE ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:
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NOT YES SURE NO	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	a. Escape only (no rescue)
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	b. Emergency rescue only
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	c. Less than 5 hours per week
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	d. Less than 2 hours per day
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	e. 2 to 4 hours per day
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	f. Over 4 hours per day
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	12. During the period you are using the respirator(s), is your work effort:
	a. Light (less than 200 kcal per hour) If "YES," how long does this period last during the average shift: _____ hrs. _____ mins. <i>Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.</i>
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	b. Moderate (200 to 350 kcal per hour) If "YES," how long does this period last during the average shift: _____ hrs. _____ mins. <i>Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.</i>
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	c. Heavy (above 350 kcal per hour) If "YES," how long does this period last during the average shift: _____ hrs. _____ mins. <i>Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8- degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).</i>
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using the respirator? If "YES," describe this protective clothing and/or equipment:
	a. _____ e. _____
	b. _____ f. _____
	c. _____ g. _____
	d. _____ h. _____
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	14. Will you be working under hot conditions (temperature exceeding 77 degrees Fahrenheit)?
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	15. Will you be working under humid conditions?
	16. Describe the work you'll be doing while you're using your respirator(s):
	17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:
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18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Name of toxic substances	Estimated maximum exposure level per shift:	Duration of exposure per shift
a. _____	a. _____	a. _____
b. _____	b. _____	b. _____
c. _____	c. _____	c. _____
d. _____	d. _____	d. _____
e. _____	e. _____	e. _____
f. _____	f. _____	f. _____

The name of any other toxic substances that you'll be exposed to while using your respirator(s):

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security):

Non-DHS/Non-County Workforce Member Signature

Date

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 C.F.R. Part 1635

PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL TO COMPLETE NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:
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**FOR COMPLETION BY A PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL
PROVIDE A COPY OF THIS PAGE TO THE WORKFORCE MEMBER**

PART 1: Fit Testing Recommendation – Based on Questionnaire

☐ Questionnaire above reviewed.

☐ Medical approval to receive Fit Test:

- ☐ Disposable Particulate Respirators (N-95)
- ☐ Replaceable Disposable Particulate Respirator ☐ a. Half-Facepiece ☐ b. Full Facepiece
- ☐ Powered Air-Purifying Respirators (PAPRs) ☐ a. Tight Fitting
- ☐ Self-Contained Breathing Apparatus (SCBA)

Recommended time period for next questionnaire: ☐ 4 years ☐ Other _____ with justification _____

Date Completed: _____ Next Due Date: _____

Any recommended limitations for respirator use on workforce member: _____

- ☐ The above workforce member has not been cleared to be fit tested for a respirator.
- ☐ Additional medical evaluation is needed. Physician or Licensed Health Care Professional to complete Part 2 below.
- ☐ Medically unable to use a respirator.

☐ Informed workforce member of the results of this examination.

Comments: _____

PART 2: Additional Medical Evaluations ☐ Not Applicable

☐ Medical evaluation completed.

☐ Medical Approval to Receive Fit Test:

- ☐ Disposable Particulate Respirators (N-95)
- ☐ Replaceable Disposable Particulate Respirator ☐ a. Half-Facepiece ☐ b. Full Facepiece
- ☐ Powered Air-Purifying Respirators (PAPRs) ☐ a. Tight Fitting
- ☐ Self-Contained Breathing Apparatus (SCBA)

Recommended time period for next questionnaire: ☐ 4 years ☐ Other _____ with justification _____

Date Completed: _____ Next Due Date: _____

Any recommended limitations for respirator use on workforce member: _____

☐ Medically unable to use a respirator.

☐ Informed workforce member of the results of this examination.

Comments: _____

Non-DHS/Non-County Workforce Member Signature		Date	
Physician or Licensed Health Care Professional Signature	Print Name	License No.	Date
Facility Name/Address		Phone No.	

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:
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DHS-EHS OFFICE STAFF ONLY			
Completion of this form:	Reviewed By (Print)	Signature	Date

GENERAL INFORMATION

THIS QUESTIONNAIRE IS TO BE REVIEWED BY A PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL.

8 CCR §5144

1. General. DHS-EHS or non-DHS/non-County workforce member's (WFM) School/Employer shall provide a medical evaluation to determine the WFM ability to use a respirator, before the WFM is fit tested or required to use the respirator in the workplace. DHS-EHS may discontinue a WFM's medical evaluations when the WFM is no longer required to use a respirator.
2. Medical evaluation procedures.
 - a. DHS-EHS or non-DHS/non-County WFM School/Employer shall identify a physician or other licensed health care professional (PLHCP) to perform medical evaluations using a medical questionnaire or an initial medical examination that obtains the same information as the medical questionnaire.
 - b. The medical evaluation shall obtain the information requested by this questionnaire in Sections 1 and 2, Part
3. Follow-up medical examination.
 - a. DHS-EHS or non-DHS/non-County WFM School/Employer shall ensure that a follow-up medical examination is provided for a non-DHS/non-County WFM who gives a **positive response to any question among questions 1 through 8 in Section 2, Part A** of this questionnaire or whose initial medical examination demonstrates the need for a follow-up medical examination.
 - b. The follow-up medical examination shall include any medical tests, consultations, or diagnostic procedures that the PLHCP deems necessary to make a final determination.

If WFM is unable to be fit-tested or has failed the fit test, WFM must be provided with a powered air-purifying respirator (PAPR).

This form and its attachment(s), if any, such as medical records shall be maintained and filed at non-DHS/non-County WFM School/Employer. The School/Employer shall verify completeness of DHS-EHS form(s) and ensure confidentiality of non-DHS/non-County WFM health information.

Upon request by DHS-Employee Health Services (EHS), the non-DHS/non-County WFM School/Employer shall have this form and its attachment(s) readily available within four (4) hour. All non-DHS/non-County workforce member health records are confidential in accordance with federal, state and regulatory requirements.

Health records will be maintained by DHS-EHS or non-County WFM School/Employer and kept for thirty (30) years after the workforce member's employment/assignment ends, in accordance with State and Federal medical records standards and DHS policies and procedures.

DHS-EHS will obtain the workforce member's written authorization before using or disclosing medical information, include to self, unless the disclosure is required by State or Federal law such as to a public health authority or governmental regulatory agency.

Workforce members have the right to access their medical records and obtain a copy, thereof, within fifteen (15) days after the request.

A copy of the respiratory protection regulation Title 8 CCR §5144 and §5199 can be found at <http://www.dir.ca.gov/title8/5144.html> and <http://www.dir.ca.gov/Title8/5199.html>

**ATD RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE**
GENERAL INFORMATION on last page
Questionnaire for N-95 Respirator**COMPLETE ONCE EVERY FOUR (4) YEARS OR AS NEEDED**

This Appendix is Mandatory if the Employer chooses to use a Respirator Medical Evaluation Questionnaire other than the Questionnaire in Section 5144 Appendix C (Form O-NC).

To the PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL: Answers to questions in Section 1, and to question 6 in Section 2 do not require a medical examination. Workforce member must be provided with a confidential means of contacting the health care professional who will review this questionnaire.

To the WORKFORCE MEMBER: Can you read and understand this questionnaire (check one): ☐ Yes ☐ No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Please complete this questionnaire in PEN and present to the staff at the examination clinic. **To protect your confidentiality, it should not be given or shown to anyone else.** On the day of your appointment, you must bring a valid driver's license or other form of identification which has both your photograph and signature.

SECTION 1

The following information must be provided by every workforce member who has been selected to use any type of respirator (please print).

				TODAY'S DATE:	
LAST NAME		FIRST, MIDDLE NAME		BIRTHDATE	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
HEIGHT FT IN	WEIGHT LBS	JOB CLASSIFICATION		IDENTIFICATION NO.	
PHONE NUMBER		Best Time to reach you?	Has your employer told you how to contact the health care professional who will review this questionnaire? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Check type of respirator you will use (you can check more than one category):

☐ N, R, Or P disposal respirator (filter-mask, non-cartridge type only)

☐ Other type (specify): _____

Have you worn a respirator?

☐ Yes ☐ No

If "yes", what type:

SECTION 2

Questions 1 through 6 below must be answered by every workforce member who has been selected to use any type of respirator (please check "YES", "NOT SURE" or "NO").

YES	NOT SURE	NO	
			1. Have you ever had the following conditions?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Allergic reactions that interfere with your breathing?
			If "yes," what did you react to? _____

CONTINUE ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:
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YES	NOT SURE	NO	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Claustrophobia (fear of closed-in places)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Do you currently have any of the following symptoms of pulmonary or lung illness:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Shortness of breath when walking fast on level ground or walking up a slight hill or incline
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Have to stop for breath when walking at your own pace on level ground
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Shortness of breath that interferes with your job
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Coughing that produces phlegm (thick sputum)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e. Coughing up blood in the last month
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	f. Wheezing that interferes with your job
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	g. Chest pain when you breath deeply
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	h. Any other symptoms that you think may be related to lung problems: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Do you currently have any of the following cardiovascular or heart symptoms?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Frequent pain or tightness in your chest
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Pain or tightness in your chest during physical activity
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Pain or tightness in your chest that interferes with your job
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Any other symptoms that you think may be related to heart problems: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Do you currently take medication for any of the following problems?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Breathing or lung problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Heart trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Nose, throat or sinuses
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Are your problems under control with these medications?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. If you've used a respirator, have you ever had any of the following problems while respirator is being used? (If you've never used a respirator, check the following space and go to question 6).
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Skin allergies or rashes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. General weakness or fatigue
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Any other problem that interferes with your use of a respirator
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Would you like to talk to the health care professional about your answers in this questionnaire?
Non-DHS/Non-County Workforce Member Signature			Date

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 CFR Part 1635

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:
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**FOR COMPLETION BY A PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL
PROVIDE A COPY OF THIS PAGE TO THE WORKFORCE MEMBER**

Part 1: Fit Testing Recommendation – Based on Questionnaire

☐ Questionnaire above reviewed.

☐ Medical Approval to Receive Fit Test

- ☐ Disposable Particulate Respirators (N-95)
- ☐ Replaceable Disposable Particulate Respirator ☐ a. Half-Facepiece ☐ b. Full Facepiece
- ☐ Powered Air-Purifying Respirators (PAPRs) ☐ a. Tight Fitting
- ☐ Self-Contained Breathing Apparatus (SCBA)

Recommended time period for next questionnaire: ☐ 4 years ☐ Other _____ with justification _____

Date Completed: _____ Next Due Date: _____

Any recommended limitations for respirator use on workforce member: _____

- ☐ The above workforce member has not been cleared to be fit tested for a respirator.
- ☐ Additional medical evaluation is needed. Physician or Licensed Health Care Professional to complete Part 2 below.
- ☐ Medically unable to use a respirator.

☐ Informed workforce member of the results of this examination.

Comments: _____

Part 2: Additional Medical Evaluations ☐ NOT APPLICABLE

☐ Medical evaluation completed.

☐ Medical Approval to Receive Fit Test

- ☐ Disposable Particulate Respirators (N-95)
- ☐ Replaceable Disposable Particulate Respirator ☐ a. Half-Facepiece ☐ b. Full Facepiece
- ☐ Powered Air-Purifying Respirators (PAPRs) ☐ a. Tight Fitting
- ☐ Self-Contained Breathing Apparatus (SCBA)

Recommended time period for next questionnaire: ☐ 4 years ☐ Other _____ with justification _____

Date Completed: _____ Next Due Date: _____

Any recommended limitations for respirator use on workforce member: _____

☐ Medically unable to use a respirator.

☐ Informed workforce member of the results of this examination.

Comments: _____

Non-DHS/Non-County Workforce Member Signature		Date	
Physician or Licensed Health Care Professional Signature	Print Name	License No.	Date
Facility Name/Address		Phone No.	

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:
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DHS-EHS OFFICE STAFF ONLY

Completion of this form:	Reviewed By (Print)	Signature	Date
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 **GENERAL INFORMATION**

THIS QUESTIONNAIRE IS TO BE REVIEWED BY A PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL.

8 CCR §5199

Medical evaluation: DHS-EHS or non-DHS/non-County workforce member (WFM) School/Employer shall provide a medical evaluation, in accordance with 8 CCR §5144(e) of these orders, to determine the workforce member's (WFM) ability to use the respirator before the WFM is fit tested or required to use the respirator. For WFM who use respirators solely for compliance with subsections (g)(3)(A) and subsections (g)(3)(B), this alternate questionnaire may be used.

8 CCR §5144(e)

1. General. DHS-EHS or non-DHS/non-county WFM School/Employer shall provide a medical evaluation to determine the WFM's ability to use a respirator, before the WFM is fit tested or required to use the respirator in the workplace. DHS-EHS may discontinue a WFM's medical evaluations when the WFM is no longer required to use a respirator.
2. Medical evaluation procedures.
 - a. DHS-EHS or non-DHS/non-County WFM School/Employer shall identify a physician or other licensed health care professional (PLHCP) to perform medical evaluations using a medical questionnaire or an initial medical examination that obtains the same information as the medical questionnaire.
 - b. The medical evaluation shall obtain the information requested by this questionnaire in Sections 1 and 2, Part A.
3. Follow-up medical examination.
 - a. DHS-EHS or non-DHS/non-County WFM School/Employer shall ensure that a follow-up medical examination is provided for a WFM who gives a **positive response to any question among questions 1 through 8 in Section 2, Part A** of this questionnaire or whose initial medical examination demonstrates the need for a follow-up medical examination.
 - b. The follow-up medical examination shall include any medical tests, consultations, or diagnostic procedures that the PLHCP deems necessary to make a final determination.

If WFM is unable to be fit-tested or has failed the fit test, WFM must be provided with a powered air-purifying respirator (PAPR).

This form and its attachment(s), if any, such as medical records shall be maintained and filed at non/DHS/non-County WFM School/Employer. The School/Employer shall verify completeness of DHS-EHS form(s) and ensure confidentiality of non-DHS/non-County WFM health information.

Upon request by DHS-Employee Health Services (EHS), the non-DHS/non-County WFM School/Employer shall have this form and its attachment(s) readily available within four (4) hours.

All workforce member health records are confidential in accordance with federal, state and regulatory requirements.

Health records will be maintained by DHS-EHS or non-DHS/non-County WFM School/Employer and kept for thirty (30) years after the workforce member's employment/assignment ends, in accordance with State and Federal medical records standards and DHS policies and procedures.

DHS-EHS will obtain the workforce member's written authorization before using or disclosing medical information, include to self, unless the disclosure is required by State or Federal law such as to a public health authority or governmental regulatory agency.

Workforce members have the right to access their medical records and obtain a copy, thereof, within fifteen (15) days after the request.

A copy of the respiratory protection regulation Title 8 CCR §5144 and §5199 can be found at <http://www.dir.ca.gov/title8/5144.html> and <http://www.dir.ca.gov/Title8/5199.html>